COMMUNITY HEALTH REPRESENTATIVE

Policy Summit Report

Community Health Representative Policy Summit: Certification, Reimbursement and Sustainability for Healthy Communities

September 1, 2015

Flagstaff, Arizona

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THE UNIVERSITY OF ARIZONA
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Executive Summary

On September 1, 2015, 15 Tribal Community Health Representative (CHR) Programs from across Arizona came together for the first time in Flagstaff, Arizona to participate in the ***Community Health Representative (CHR) Policy Summit: Certification, Reimbursement and Sustainability for Healthy Communities***. The CHR programs discussed three very important policy topics related to health care reform.

Mechanism to Finance CHRs through Medicaid

In July 2014, a new Center for Medicare and Medicaid Services (CMS) ruling now allows state Medicaid programs to request an amendment to current rules that will allow for reimbursement of community-based preventative services, including those provided by nonlicensed health professionals, which include both Community Health Workers (CHW) which is the official job title recognized by the US Bureau of Labor and which Community Health Representative or CHRs fall under.

Further Integration of CHRs into Health Care Delivery

A growing body of evidence has demonstrated that CHW/CHRs working within the health care systems and as part of an interdisciplinary health team have documented improved health outcomes and reduced health care cost, especially in the areas of chronic disease management, hospital readmission, and utilization of emergency room services. Currently, the Arizona Health Care Cost Containment System (AHCCCS) is seeking approval in their Section 1115 Waiver application to CMS for the "American Indian Medical Home" which may be an opportunity to further integrate CHRs through health care teams to coordinate care ultimately improving health outcomes and reducing costs.

Voluntary Certification of CHRs

Although CHRs are formally recognized by the Indian Health Service (IHS) and have been allocated funding annually since 1968; there is no formal certification recognizing CHRs as a workforce. In order to prepare for the financial mechanisms available to integrate and expand the CHR workforce within health care and public health systems a standardized credentialing process needs to occur. The policy summit sought CHRs perspectives and desires on the issue of voluntary statewide certification efforts currently taking place in Arizona.

Recommendations

CHR programs identified the following priorities for advancing and sustaining the CHR workforce:

1. **Inform tribal stakeholders** about CHR Voluntary Certification and how it further elevates the CHR profession.
2. **Inform tribal health care systems about potential Medicaid reimbursement of CHR Services** and how the Section 1115 Waiver may provide for this opportunity as well as the cost savings incurred when CHRs are included as a member of the health care team.
3. **Create awareness among CHR stakeholders about the role and impact of CHRs** on the social determinants of health and wellbeing, especially the positive health outcomes.
4. **Inform tribal health care systems how leveraging and expanding the role of CHRs within existing programs** can maximize resources and benefit population health. Existing programs include oral health, behavioral health, Women Infants and Children (WIC), elder care, and the Special Diabetes Programs.
5. **Identify and secure funding to provide consistent meetings among the 19 CHR programs** to continue dialogue and progress on CHR priorities and issues to include certification and reimbursement.

Tribal governance was considered vital to advancing the CHR workforce through tribal resolutions that outline mechanisms to strengthen, integrate, leverage and expand the CHR workforce to improve health outcomes among American Indian communities of Arizona.

Introduction

On September 1, 2015, 15 Tribal Community Health Representative Programs from across Arizona came together for the first time in Flagstaff, Arizona to participate in the ***Community Health Representative (CHR) Policy Summit: Certification, Reimbursement and Sustainability for Healthy Communities***. This event brought together several leaders and experts in the field of CHWs and CHRs to discuss major shifts in CHW/CHR related policy and the unique opportunities CHRs have to advance their workforce.

The objectives of the meeting included:

1. Explore national, state and tribal issues regarding CHWs/CHR reimbursement through Medicaid;
2. Increase awareness of Arizona and New Mexico CHW certification processes and legislation; and
3. Explore benefits and costs to CHW/CHR certification in Arizona.

The CHR Policy Summit was inspired by existing policy efforts focused on sustaining the broader Community Health Workers (CHW) workforce throughout the state of Arizona. In an interest to build relationships with CHR Programs, staff members of the University of Arizona, Arizona Prevention Research Center and the Center for American Indian Resilience wrote a small seed grant to the Arizona Health Education Center (AHEC) Small Research Grants Program. The grant was awarded in Month, Year. AHEC funds provided the opportunity to create dialogue around specific opportunities for CHR workforce sustainability including, training, career progression and reimbursement. During the months of January through June AHEC funded a series of listening sessions with various CHR Programs throughout the state. Through these meetings, the need and desire for CHRs to come together to share experiences, resources and opportunities for advancement became apparent.

Simultaneous to these listening sessions, collaborations on statewide Community Health Worker workforce issues had emerged among members of the Arizona Prevention Research Center, the Center for American Indian Resilience, and the Advisory Council on Indian Health Care, the Inter Tribal Council of Arizona, Inc. and the Navajo Nation Community Health Representative Program.

It was through these partnerships and recognition of the important issues and opportunities facing CHR programs nationally, that planning for the CHR Policy Summit began in the summer 2015. The CHR Policy Summit provided the platform to bring together CHR programs from across Arizona to learn and discuss CHR workforce sustainability and the existing and emerging policy opportunities to strengthen and expand the CHR workforce.

This report will provide:

1. Background and impetus for the CHR Policy Summit;
2. A description of the proceedings of the Policy Summit;
3. Results from the CHR Workforce Sustainability Roundtable Discussion which were conducted during the Policy Summit;
4. The Results from the Community Health Representative Workforce Assessment; and
5. Conclusion and Next Steps

Background and Impetus for CHR Policy Summit

History of the CHR Workforce in Tribal Communities

In the 1960s, American Indian Indigenous communities in the US identified the need and lobbied for community health professionals to improve cross-cultural communication between Native communities and predominantly non-Native health care providers. A federally funded community health worker (CHW) program emerged. CHWs in Indian Country are known as community health representatives (CHRs) who are characterized as community leaders who share the language, socioeconomic status and life experiences of the community members they serve. For more information of the history and development of the Indian Health Service, Community Health Representative Program please visit: http://www.ihs.gov/chr/index.cfm?module=history

There are currently 1,700 CHRs representing 264 tribes. A CHR is considered a frontline public health worker who is a trusted member of and or has an unusually close understanding of the community served. This trusting relationship enables CHRs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHR also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

In Arizona, 19 of the 22 Tribes manage and operate their own CHR Program. CHRs are estimated to represent 30% of the total CHW workforce in the state.

Mae-Gilene Begay, Navajo Nation CHR Program and Diane Abeyta, New Mexico Health Department CHW Program Sharing Experiences of CHW Certification in New Mexico

Financing and Reimbursement of CHR Workforce

Reforms in health care in the United States have incentivized the shift toward a value-based reimbursement structure that requires evidence of favorable outcomes among the patient population. The Affordable Care Act (ACA) through expanding payment methods and focusing on value and quality of care may constitute a landmark in the movement to integrate Community Health Workers and Community Health Representatives within the mainstreams of health care, public health, and social services.

The Arizona Health Care Cost Containment System (AHCCCS) through its Section 1115 Demonstration Waiver is proposing to offer services that support an Indian Health Medical Home Program. AHCCCS is proposing to reimburse for Primary Care Case Management, a 24-hour call line, diabetes education and after-hospital care coordination. Such coordinated and medical home models include the focus on patient-and family-centered care through health care teams of which CHRs can play an impactful role. This may be an opportunity for CHRs to be included. Scientific evidence has demonstrated that CHWs, including CHRs are integral contributors in collaborative health care teams focused on providing comprehensive care. Utilizing their unique position, skills and training CHW/CHRs have been shown to improve patient outcomes and reduce system costs for health care by assisting community members in avoiding unnecessary hospitalization and other forms of more expensive acute care.

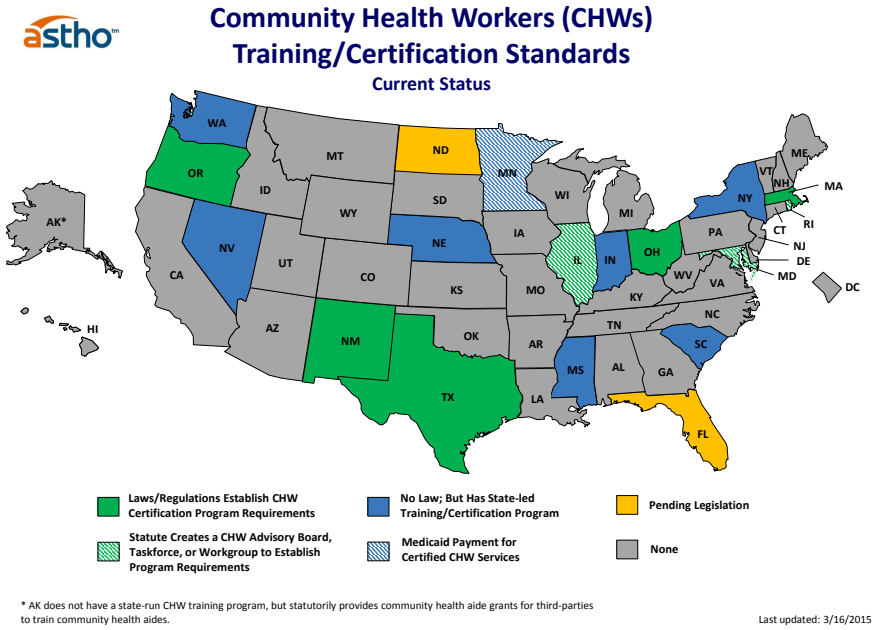
Specifically, CHW/CHRs are increasingly recognized for their value in improving the efficacy of care and contributing to the provision of high quality and coordinated care. Well-functioning multidisciplinary care teams that include a CHW/CHR have been identified as contributing to the efficacy of Patient-Centered Medical Homes (PCMH), similar to that of the Indian Health Medical Home, Accountable Care Organizations (ACO), and Community Health Teams. In

addition to coordinated care, ACOs, PCMHs and IHMHs strive to provide routine preventive care and patient education. **CHW/CHRs are well positioned to support these new models of care entities and effectively meet health reform mandates for prevention, education and coordination of care.**

Voluntary Certification of Community Health Representatives (CHR)

Although CHRs are formally recognized by the Indian Health Service (IHS) and have been allocated resources annually since 1968, there is no formal or state recognized certification of CHRs as a workforce. In Arizona, non-American Indian Community Health Workers (CHWs) are also not fully recognized as a professional workforce, and thus lack the sustained financial support required to meet the demand for this workforce. In order to standardize CHW workforce definition, competencies, scope of work and training – several states have moved to certify the CHW workforce. See figure below. In 2010, the US Bureau of Labor formally recognized the Community Health Workers (CHW) as a workforce.

In 2013 CHWs were included in the Patient Protection and Affordable Care Act as distinct members of the health care team. In July of 2014, the Centers for Medicaid and Medicare (CMS) services issued new guidance that allowed for reimbursement of preventive services offered by unlicensed professionals such as CHWs if states opt in. These national policy developments have tremendous implications for how the CHW and the CHR workforce will continue to evolve, particularly with regard to the creation of statewide training and credentialing standards. Therefore many states have moved toward the formal certification and adoption standards or training of the CHW workforce.



OCHW
Office of Community Health Workers

New Mexico State Health Department, Office of Community Health Workers

During the CHR Policy Summit, we looked to our neighboring state of New Mexico for guidance to integration of tribal CHR programs. In 2003, New Mexico established the New Mexico Community Health Worker (CHW) Advisory Council (NMCHWAC) committed to achieving integration of CHWs into New Mexico's health systems and community settings. The Advisory Council "is a critical partner working with the Office of Community Health Workers, NM Department of Health to develop a statewide training and certification process for CHWs. The Advisory Council advocates for CHWs within state government and serves as a forum for community members to express their perspectives on health and the role of the CHW in improving community and individual health outcomes. The primary responsibility of the Office of Community Health Workers is to develop a standardized, statewide training program and a certification process for community health workers (CHW) and to support the CHW profession and workforce." New Mexico stands out as one of only two states with an Office of Community Health Workers. CHR programs are represented on the Advisory Council and inform the decisions of the New Mexico Office of Community Health Workers.

In 2014, the National Association of Community Health Representatives or NACHR, the national professional association of CHRs conducted a survey of its CHR membership. NACHR identified lack of awareness of the impact

of CHR and the CHR program; CHR certification and credentialing; CHR integration as members of the health care team; funding; transporting; training and salaries as top priorities. NACHR outlined several areas for CHR workforce development including: certification, financing, best practices, training and continuing education.

As CHW stakeholders of Arizona begin to explore voluntary certification of the Arizona CHW workforce, it is important that CHRs are integrally involved in informing the decision on the issue of certification as it relates to tribal CHR Programs.

Policy Summit Overview and Content

The Policy Summit brought together several experts in the area of Community Health Worker and Community Health Representative workforce and health policy. Below is description of the presentation topics and the individuals that presented at the Policy Summit. All presentations are located at the Advisory Council on Indian Health Care website. **https://acoihc.az.gov/health-care-initiatives** See Appendix B for CHR Policy Summit Agenda.

Presentation 1: National CHW/CHR Sustainability Initiatives
***Samantha Sabo**, Arizona Prevention Research Center, Zuckerman College of Public Health, University of Arizona*

This session summarized the National policy climate regarding Community Health Worker certification, financing and integration within the context of U.S. health reform.

Flor Redondo, President, Arizona Communtiy Health Worker Assoation (AzCHOW) and Yanita Soto, Arizona Department of Health, Community Health Worker Manager

Presentation 2: CHW Sustainability, Reimbursement, Certification in New Mexico

***Mae-Gilene Begay**, Director, Navajo Community Health Representative Program and Chair, Community Health Worker Section, American Public Health Association (APHA)*
***Diana Abeyta**, Tribal and Northern Coordinator, Office of Community Health Workers, New Mexico Department of Health.*

This session described the New Mexico Community Health Worker certification process including the development and activities of the board of certification, the ways in which this board engaged Tribal CHR programs, and the impact of CHW certification thus far and the opportunities for Medicaid reimbursement for CHW services in the state.

Presentation 3: Arizona CHW Workforce Coalition Efforts Toward Statewide CHW Certification

***Presenters: Floribella Redondo**, President Arizona Community Health Worker Outreach Network (AzCHOW)*
***Yanitza Soto**, Community Health Worker Manager, Arizona Department of Health*
***Andy Logue**, MPH/JD Intern, Zuckerman College of Public Health, University of Arizona*

This session outlined the three major CHW stakeholder groups; Arizona Community Health Worker Outreach Network (AzCHOW), the Arizona Community Health Worker Coalition, and the Arizona Department of Health Services Community Health Worker Leadership Council, in the state of Arizona organizing to understand and influence the ways in which CHWs are integrated and financed within both public health and health care systems. This session also summarized the coalition's efforts to shape and develops a Sunrise Application required to legislate the certification or licensing of any health professional in the state of Arizona. The Sunrise application has been tabled until further input into the application can be provided. See Appendix C for Organizational Chart of Key CHW Stakeholders

Founded in 2001, **Arizona Community Health Worker Outreach Network (AzCHOW)** is a statewide organization designed to create unity while preserving cultural diversity among community health workers. AzCHOW is the professional association of the CHW workforce, including such titles as Promotoras de Salud, Community Heath Representatives, Peer Health Educators and the list goes on. AzCHOW has had representation from CHRs in the past and is currently requesting CHR participation on its board. If you are a CHR and would like to be a board member please contact Flor Redondo flor.alasdefe@gmail.com

Established in **2013, Arizona Community Health Worker Coalition** is a multi-stakeholder advocacy coalition of over 150 academic, public health, health care, tribal and non-profit organization members working to sustain and advance the CHW workforce in Arizona. CHWs is the umbrella title and includes Promotoras, Community Health Representatives, Peer Educators, Patient Navigators and beyond. The Coalition has five working groups including sustainability, research, advocacy and certification. Membership is open. Meetings are quarterly and meet face to face and by phone conference. Contact Monica Munoz to be added to the list serve and attend meetings munoz@email.arizona.edu.

Established in 2014, the **Arizona Department of Health Services Community Health Worker Leadership Council** is a 21-member advisory council and serves to support and provide expertise on current and future infrastructure for the CHW Workforce throughout Arizona. The Leadership Council is currently soliciting Tribal CHR Program representation in its membership. This leadership council meets quarterly face to face and via phone conference typically in Phoenix area.

Session 4: Summary and Implications for Tribal CHR Programs and Beyond

***Presenter: Alida Montiel**, Director of Health Systems, Inter Tribal of Council of Arizona, Inc.*
This session focused on the role of CHR's in the Indian Health System and mechanisms by which preventative services deemed mandatory or optional services may be incorporated in the Section 1115 Demonstration in order to institute 100% Federal pass-through reimbursement to Tribes.

Session 5: CHR Workforce Sustainability Roundtables

This session focused on small group discussions on the benefits and costs to CHR certification and reimbursement. Each session leader summarized main points made by participants. Information for this session is detailed in the next section.

CHR Program Round Table Discussions

CHR Workforce Sustainability Roundtable Discussion

During the CHR Policy Summit a series of round table discussions were conducted. Discussions focused on 10 questions related to:

- **Topic 1: CHR workforce voluntary certification**
- **Topic 2: Opportunities for reimbursement**
- **Topic 3: Expansion of the workforce and priority areas for moving forward.**

Questions were adapted from a set of questions used with non-American Indian CHWs and CHW employers throughout the state. A member of the planning committee and a note taker facilitated roundtables.

The following section includes a summary of participant responses across CHR programs by question.

Topic 1: Community Health Representative Voluntary Certification

1. When you hear the word CHR certification, what is the first thing that comes to mind?

CHR Programs described CHR workforce certification as the way in which a profession becomes formalized or standardized. For CHRs, certification was thought to legitimize the CHR profession and signified that there is specific knowledge, training and competencies required and possessed by the CHR.

2. Why would it be beneficial to have voluntary CHR certification?

CHR Programs described several benefits to a voluntary process of certification of CHRs. Benefits included the validation a certification can give to the CHR workforce, such as to elevate the profession. If the certification process is voluntary and many CHRs take advantage of the opportunity to get certified, it demonstrates the passion and commitment the CHRs have for their profession and for the population and community. Some CHRs and CHR programs thought certification should be consistent across all CHRs and that the supervisor plays a key role in motivating the CHR to become certified. For many CHR programs, certification was related to reimbursement for CHR work - in that in order to be eligible for reimbursement from other sources beyond IHS, a CHR might need to be certified.

3. What are your concerns about voluntary certification?

Some of the concerns regarding voluntary statewide certification of CHRs include the ability for CHR programs to come to consensus on the value of certification and the process for which to certify CHRs. Others were concerned that certification may create conflict among certified versus non-certified CHRs. CHRs questioned whether veteran CHRs or those who have been employed as a CHR for a long period of time would be interested in becoming certified. Others questioned whether there would be a differentiation in pay grade among certified and non-certified CHRs, or if having a certificate would give an unfair advantage to CHRs who have the certification. Some participants thought that certification should be mandatory and not voluntary. CHR Programs mentioned the need for supervisors to support CHRs in getting certified.

4. Do you believe that there is value in the state's creation of a Community Health Worker Board of Certification or credentialing?

CHRs and CHR programs saw value in the development of a statewide Community Health Worker Board of Certification or Credentialing and identified some of the unique considerations of such a statewide system for sovereign tribal nations. First and foremost was the recognition of tribal sovereignty and the requirement of CHR Programs to work within the policy making structures of their own tribal governments and health boards to make

the case for certification and set the standard for CHR certification. If consensus on certification of CHRs could be achieved at the level of tribal government, then a CHR certification is in essence a guarantee by the tribe that the CHR workforce has achieved competency in their job. In terms of the actual Certification Board, CHR Programs wanted to see tribal CHR Program representation and participation by the CHR workforce themselves.

Community Health Representatives from Tohono O'odham Sharing Ideas on CHR Certification

5. What are the barriers that should be considered when developing standardized statewide certification training?

Some of the barriers to be considered in developing standardized statewide certification training include the language in which the training is offered, and the level of cultural competency and relevancy to the CHR program. Others mentioned the cost of the certification – which should not be too high as to exclude CHRs and or CHR Programs from participating. The timing of certification and the time commitment for CHRs to obtain certification was also an issue to be considered as many CHR programs were described as underfunded and short staffed. The CHR scope of work was also an issue that must be considered as CHR programs operate in unique ways with distinct processes for recruitment, trainings and oversight. Overall a statewide certification must consider and respect the sovereignty of each tribe the inter-tribal relationships among tribes and the tribal-state relationships and processes for making policy decisions. Mutual respect among and between tribes and state government was viewed as important. Inter-governmental agreements could be a mechanism to address such issues. Lastly, the certifying organizations or body must be considered as they may require unique CHR competencies.

6. What would be the best way to recognize CHR job experience in the certification process?

CHR Programs suggested several ways to recognize CHR job experience in the certification process. Years of experience as a CHR was first and foremost in terms of demonstrating job experience. Other ways to recognize experience included number of years within a certain type of system, or a geographic location, such as rural versus urban areas and the types of services the CHR provided. CHR Programs wanted to honor and give priority for years in the CHR field as opposed to a formal academic training or degrees or types of certification and licensure. The quality of the experience as a CHR was also considered very important.

7. Should there be a grandfathering process for certification of CHRs?

Certification of CHRs through a grandfathering provision is a process in which all CHRs currently employed and meet pre-designated criteria are automatically granted a certification. While all new and incoming CHRs would be required to go through the process of becoming certified. Some CHR Programs believe grandfathering can take place as long as there is a mechanism for continuing education and training for those CHRs that receive certification through the grandfathering process. Some mentioned the history of grandfathering emerged because of the concern that some CHRs – who are incredibly competent in the work as a CHR may not meet the educational requirement and thus would be unable to receive the certification. Others described a tiered process to exemplify experience and expertise of CHRs and opportunities for continuing education credits. The number of and type of years of experience of the CHR was mentioned as an issue that needed to be clarified to be eligible for a certification through a grandfathering process.

8. Should CHR supervisors also be trained and certified to supervise CHRs?

The majority of CHR Programs agreed that CHR supervisors should be trained and certified to supervise CHRs. Some felt that CHR supervisors would benefit from training and certification as a supervisor. Such a process was thought to increase the likelihood that a CHR supervisor fully understands the competencies and scope of practice of CHRs. Supervisor certification was considered to improve the management capability of supervisor and support the unique needs of CHRs, such as supporting the CHR autonomy to make decisions regarding how best to serve clients and community. Certification of the supervisor was thought to enhance the trust between CHR and the supervisor as the supervisor through his or her training will have meaningful knowledge of the CHR profession and how to properly manage and support CHR growth and performance.

Topic 2: Financing and Reimbursement of CHR Workforce

As described earlier, given the policy windows of opportunity through health reform, the following section describes CHR program participant ideas related to financing and reimbursement of the CHR workforce.

1. What opportunities exist to increase the CHR workforce or hire more CHRs?

CHR Programs identified several opportunities to increase the CHR workforce. CHR Programs agreed that reimbursement through the Medicaid (AHCCCS) systems and or third party billing would help to increase the size of the workforce. Creating a mechanism for which CHR services are billable services would also likely grow the workforce. The importance of leveraging and expanding the role of CHRs within existing public health programs such as: oral health, behavioral health, Women Infants and Children (WIC) and the Special Diabetes Programs was identified by participants as ways to integrate and expand the role of CHRs. Some thought that existing dollars for these programs could be redirected to support CHRs in conducting ongoing follow up, home visiting and social support to clients participating within these programs. CHR Programs thought better awareness of CHR roles and their scope of practice including the impact of CHRs on health outcomes was needed to increase the hiring of more CHRs. CHRs proposed the creation of internships and mentorships for the younger generation of CHRs through a curriculum in community health or community health representative core competencies as to obtain a CHR certification upon high school graduation. CHR Programs mentioned the importance of CHRs knowing what resources are available for potential partnerships. Knowledge of the competing priorities in health care workforce and focus at the tribal level was also mentioned as important information to know in moving forward. Specialized diabetes and dental health programs; grants and understanding tribal politics could result in hiring more CHRs.

2. What are the next steps or strategies to increase the CHR workforce in Arizona?

CHR Programs identified several next steps to increase the CHR workforce, which spanned the following levels; workforce development, public health systems and health care systems.

At the **workforce development level,** CHR Programs described the need for developing mentorship and internship opportunities for high school students to learn the role of CHRs and encourage them to become CHRs themselves. CHR Programs mentioned ways in which high school students could be trained as a CHR while in high school such as: (1) the development of a CHR shadowing or mentorship program, (2) a training program that focused on the CHR scope of practice and competencies. Such a high school program could then be linked to tribal college initiatives aimed at growing the public health workforce. One such example is the intentional effort the Navajo Nation CHR Program has made to strengthen the CHR workforce by requiring CHRs to enroll in the Dine College Certificate Program in Public Health. Through this collaboration – CHRs employed by Navajo Nation complete a certificate in public health, which can be applied to an Associates of Arts (AA) degree. Such a workforce investment at the high school and tribal or community college level was considered a strategy for which to train the new generation of CHRs and strengthen the capacity of the existing workforce.

For others, **leveraging opportunities with the existing public health systems** could lead to increases in CHR hiring and or integration. Programs mentioned included oral health initiatives, specifically the dental health community coordinator role, Women Infants and Children (WIC) and the Special Diabetes Programs. CHRs were identified as a workforce that could be integrated into the schools to encourage children to make healthy lifestyle choices.

Several strategies were identified within the **health system**, mainly the ways in which CHRs could be integrated into primary care and new models of the coordination of care. CHRs were identified as members of the health care team, including the telemedicine and the patient discharge team. Others described how CHRs could use the Resource and Patient Management Systems (RPMS) to coordinate care and communicate with other members of the health care team. More direct collaboration and communication with public health nurses (PHNs) was identified as mechanism to help create an integrated care model and team. Yet, high turnover rates among PHNs and separate funding streams for PHNs were identified as challenges for collaboration with CHRs. CHR Programs stated the importance of informing the public that CHR services are not linked to one specific group, like elders, but span the lifespan.

3. What are the barriers that should be considered?

CHR Programs expressed the importance of stakeholders, health providers and legislators understanding the role and scope of practice of a CHR.

CHR Programs stated that showing the value of CHRs within the health system and care team will make their role clear to clinical practitioners and in turn better serve the communities in which they work. CHR Programs identified the need to be in regular meetings with providers, administrators and other community partners to share ideas and updates. CHRs wanted a one page informational handout for key stakeholders that outline CHR role, value and scope of practice. On a managerial level, CHRs discussed the need for enhanced support from their direct supervisors and managers to be more effective in the field to feel their true worth.

One area that CHRs felt they could make an impact was within the school system. CHR Programs also suggested a closer partnership with Indian Health Services (IHS), and mental health services. An innovative idea that emerged from one CHR program was to enable a CHR to be designated to a school to visit monthly and assist teachers in health promotion and mental health outreach and among students and families.

Alida Montiel of Inter-Tribal Council of Arizona Sharing Information on Health Care Policy

Funding for CHR Programs was considered a major barrier to expansion of the CHR workforce. CHR Programs identified a need to look to outside resources; foundations and corporations to supplement the dollars CHRs are currently receiving from IHS. For consistency, CHR Programs emphasized the importance of adapting and reviewing the current IHS manual that outlines the definition and scope of practice of a CHR to ensure its validity across all tribal nations. This was expressed to be extremely important when looking at the integration of CHRs into the primary health care system in both urban and rural settings.

Community Health Representative Workforce Assessment

During the Summit the planning committee also took the opportunity to assess the CHR workforce in attendance. To do this, the planning committee developed a CHR Workforce Assessment tool that was completed at the summit. The assessment assessed:

1. CHR functions, including scope of practice, role and responsibilities
2. Training and training needs
3. Health and social issues of focus
4. Barriers to hiring CHRs and advancing the workforce
5. Awareness of policies related to the advancement of the broader CHW workforce

Demographics

Among the 50 CHR participants eligible to complete the survey, 64% (n= 32) completed the CHR workforce assessment. Among the survey participants, 34% (11) self-identified as CHRs and 65% (18) as CHR supervisors, employers or organizations. Assessment respondent represent 12 (54%) of 19 CHR programs in Arizona.

Jill de Zapien, Assistant Dean for Community Programs, Zuckerman College of Public Health and Kim Russell, Executive Director, Advisory Council on Indian Health Care

Table 1. Survey Participating CHR Programs

Tribal Affiliation	Total Surveys	Percent
Tohono O'odham Nation	9	28%
Navajo Nation	5	16%
White Mountain Apache Tribe	4	13%
Hualapai Tribe	2	6%
Pascua Yaqui Tribe	2	6%
Yavapai-Apache Nation	2	6%
Colorado River Indian Tribes	1	3%
Fort Mcdowell Yavapai Nation	1	3%
Fort Yuma-Quechan Tribe	1	3%
Havasupai Tribe	1	3%
Hopi Tribe	1	3%
San Carlos Apache Tribe	1	3%
Ak-Chin Indian Community	NA	0%
Cocopah Indian Tribe	NA	0%
Fort Mojave Indian Tribe	NA	0%
Gila River Indian Community	NA	0%
Kaibab Band Of Paiutes	NA	0%
Salt River Pima-Maricopa Indian Community	NA	0%
San Juan Southern Paiute	NA	0%
Tonto Apache Tribe	NA	0%
Yavapai-Prescott Indian Tribe	NA	0%
Pueblo Of Zuni	NA	0%
Total	**32**	**100%**

NA – these CHR Programs were not present and did not have the opportunity to complete the CHR Workforce Assessment
Missing = 2

Roles and Functions

Approximately 70% of CHR Programs identified home visits, providing health education and information, translation and interpretation services, collaborating with other agencies and health screening to be the top five areas of function for CHRs. Half of CHRs performed case management, personal care, school/community based outreach, referrals/linkages to resources, home health care, office work and case finding/recruitment. Less than 30% of respondents reported working in peer education and mentoring, support groups, informal counseling, insurance enrollment and fundraising or grant writing.

Health Areas of Focus

Participating CHR programs identified screening and self-management of diabetes, prevention of chronic disease, elder health and general prevention through the promotion of nutrition and physical activity as among the top five health areas of focus. Environmental health, injury control, cancer screening

Table 2. Top Functions that CHRs Perform

Functions	Total	Percent
Home visits	32	100%
Providing health education/information	30	94%
Translation/Interpretation	24	75%
Collaborating with other agencies	23	72%
Health screening	22	69%
Case management	21	66%
Personal care	18	56%
School and community based outreach	17	53%
Refer/provide linkages to community-based resources	17	53%
Home health care	17	53%
Case finding/recruitment	17	53%
Office work	15	47%
Peer education/mentoring	9	28%
Lead support groups	7	22%
Informal counseling	7	22%
Insurance enrollment	5	16%
Fundraising / grant writing	1	3%
Total	**32**	**100%**

Table 3. Top Health Issues Community Health Workers of Focus

Health Issue	Total	Percent
Diabetes (Screening and Self-management)	28	88%
Chronic Disease Prevention	24	75%
Elder health	22	69%
Prevention (Nutrition and/or Physical Activity)	20	63%
Environmental Health	16	50%
Injury Control	16	50%
Cancer (Screening and Treatment)	16	50%
Maternal and Child Health	15	47%
Cardio Vascular Disease (Screening and Management)	13	41%
Alcohol/Substance/Tobacco User	11	34%
HIV / AIDS	11	34%
Accessing Health Services	11	34%
Sexual or Reproductive Health	11	34%
Behavioral Health / Mental Health	10	31%
Tuberculosis - TB	10	31%
Adolescent Health	7	22%
Asthma	6	19%
Occupational Health	5	16%
Dental health	4	13%
Total	**32**	**100%**

and treatment, maternal and child health and cardio vascular disease were identified by approximately half of participants. While the health issues of alcohol, substance and tobacco use, HIV/AIDS, accessing health services, reproductive health, behavioral health and tuberculosis were areas of lesser focus by CHRs. Less than 20% of CHR Programs identified adolescent health, asthma, occupational health, and dental health as their top area of focus.

Training

Approximately 70% (21) of CHR Programs reported that CHRs are required to attend formal training once hired as a CHR compared to 13% (4) who did not require any training and 20% (6) who said that training upon hire is dependent on the skills level of the candidate. The main mechanisms in which CHRs received training included: on-the-job training, and training offered through the Indian Health Services CHR Program.

CHR programs described several areas in which CHRs could benefit from training. More than three fourths of respondents reported that CHRs could benefit from training in heart disease and stroke, cancer, diabetes, falls prevention and chronic disease self-management (Table 4). Approximately 60% of CHR Programs stated that substance abuse, behavioral and lifestyle coaching and maternal and child health trainings would be beneficial for CHRs. Trainings in asthma, HIV/AIDS and smoking cessation accounted for less than 50% of responses. CHR Programs also identified training in: Rocky Mountain Spotted Fever, chronic diseases, suicide, liver disease, disaster management and nutrition to also be areas where CHRs could benefit from additional training.

Table 4. Top Trainings CHRs Would Like To Be Offered

	CHR Summit		NACHR*	
Topics	**Total**	**Percent**	**Total**	**Percent**
Heart disease and stroke	25	78%	56	57%
Cancer	23	72%	54	55%
Diabetes	23	72%	46	47%
Falls/Injury prevention	22	69%	52	53%
Chronic disease self-management	21	66%	ND	ND
Substance abuse	19	59%	47	48%
Behavioral / lifestyle coaching	19	59%	ND	ND
Maternal and child health	18	56%	1*	1%
Asthma	16	50%	ND	ND
HIV / AIDS	16	50%	30	30%
Smoking cessation	14	44%	ND	ND
Total	32		97	

*Source: * 2014 National Association of Community Health Representatives Survey*

We compared the results from the CHR Summit workforce assessment to data gathered from most recent National Association of Community Health Representatives (NACHR) conducted in 2014. Approximately 50% of respondents from the NACHR survey stated that substance abuse, falls and injury prevention and diabetes were areas that CHRs would like to learn more about. Trainings in heart disease and stroke, and cancer accounted for just fewer than 60% of respondents while 30% stated that they would benefit from HIV/AIDS training. Two other topics that are not listed in Table 4 that were stated as important areas for training included: traditional healing and the Affordable Care Act.

CHR Programs perceived several barriers in hiring and integrating CHRs into health care teams (Table 5).

Table 5. Barriers in hiring or integrating CHRs into health care teams

Barriers	**Total**	**Percent**
Lack of ability to bill insurers	15	50%
Lack of clarity about CHR value	15	50%
Lack of clarity about how they function as members of or link to a primary care team	17	57%
Lack of training of CHWs	17	57%
Total	**30**	

Opportunities For Workforce Expansion and Financing

CHRs identified several areas they are not currently being used but could be. Responses included, but are Not limited to, preventative screenings, transportation, health care team meetings, dental care, school involvement and adolescent education. See below for full list of responses from participants:

- Adolescent education, nutrition and exercise
- Cancer
- Dental
- Diet and healthy activities
- Patient care
- Medication adherence
- Medical team/home meetings
- School health
- Transportation
- Vision and hearing screening
- Women, Infants and Children (WIC)
- Medical team meetings
- Personal care
- School health

A new Center for Medicare and Medicaid Services ruling now allows Medicaid programs to request an amendment to current rules that will allow for reimbursement of community-based preventative services, including those that CHWs provide. Summit CHR Programs were asked about their awareness of this ruling as it relates to their work. Of the 31 respondents, 35% (n=11) stated that they were aware of the new ruling for reimbursement while 65% (n=20) were not.

CHR Programs stated that health/environmental assessments, infectious disease, emergency preparedness, wound care and, data entry and health insurance navigation were also part of their work. See below for an inclusive list of responses of participants.

- AHCCCS long term care application
- Social Security
- Basic wound care
- Character building
- Interpersonal relationships
- Work ethics
- Comprehensive health assessment
- Maternal assessment
- Home safety assessment
- Dialysis patients
- Emergency preparedness
- Foot care
- Fun run/walks
- Medication refills
- Transportation
- Diabetes education certification
- Rocky mountain spotted fever
- Data entry into Indian Health Services (IHS) program
- Working with public health nurse

Conclusion and Next Steps

Workforce Sustainability

Inconsistent funding streams and shifting public health priorities have stymied development of a coordinated CHW/CHR workforce. [1] Nonetheless, evidence suggests that CHW/CHR roles are converging, and are considered a distinct health profession, rather than merely complements to public health interventions.[2] In 2010, Community Health Workers, which is the umbrella term that includes CHRs, were recognized by the Bureau of Labor[3] and in 2013 CHWs were included in the Affordable Care Act as distinct members of the health care team. Furthermore, the Centers for Medicaid and Medicare services recently issued new guidance that allows for reimbursement of preventive services offered by unlicensed professionals such as CHWs if states opt in.[4] These developments have tremendous implications for how the workforce will continue to evolve, particularly with regard to possible creation of statewide training and credentialing standards.

Members of emerging professions are generally expected to pave the path for their own workforce advancement however, in at least one state the CHW workforce is overseen by another health profession. It is possible that CHWs—who are often members of marginalized populations and low-wage earners may face difficulty in leading workforce development efforts in other areas of the country as well.[5] Case studies from a few states highlight successful collaborations between CHWs and other stakeholders to make decisions about CHW training and credentialing,[6] and to pass legislation to support CHWs.[7,8]

Based on the information gathered through the CHR Policy Summit, CHRs are especially interested in developing a collective voice and creating space for further discussion regarding their own profession, including opportunities for training, advancement, integration and financing.

Workforce Financing

Reforms in health care in the United States have incentivized the shift toward a value-based reimbursement structures that require evidence of favorable outcomes.[9] CHWs, including CHRs have been recognized as integral contributors in collaborative health care teams focused on providing comprehensive care.[10-12] Utilizing their unique position, skills and training CHWs have the potential to play a significant role by improving patient outcomes and reducing system costs for health care by assisting community members in avoiding unnecessary hospitalization and other forms of more expensive acute care.[13]

Specifically, CHW/CHRs are increasingly recognized for their value in improving the efficacy of care and contributing to the provision of high quality and coordinated care.[14-17] Well-functioning multidisciplinary care teams that include a CHW/CHR have been identified as contributing to the efficacy of Patient-Centered Medical Homes (PCMH), Accountable Care Organizations (ACO), and Community Health Teams.[13] In addition to coordinated care, both ACOs, PCMHs strive to provide routine preventive care and patient education.[6,14] CHW/CHRs are well positioned to support these entities effectively meet health reform mandates for prevention, education and coordination of care.[13] The Affordable Care Act (ACA) through expanding payment methods and focusing on value and quality of care may constitute a landmark in the movement to integrate CHW/CHRs within the mainstream of health care, public health, and social services.[12]

Return on Investment

The use of CHW/CHRs is cost effective. CHW interventions improve clinical indicators,[18-21] lower risk factors in chronic disease and mental health,[22,23] and increase medication adherence in patients/clients.[21,24] CHW interventions

also contribute to the reduction in Emergency Department visits.[21,25-30] CHW/CHR integration into the primary care team and beyond is associated with reductions in cost[16,20,26,29,31,32] with a return on investment that ranges from $0.02 to $5.58 per dollar invested in CHW interventions.[16,20,21,25]

Workforce Policy

The Centers for Disease Control (CDC) released guidance late last year on policy best practice for CHWs and their programs. The CDC looked at policy components, which are discrete activities that could be part of public health policy. The CDC identified 14 CHW policy components to assess using the Quality and Impact Component (QuIC) Evidence Assessment method, which categorizes policies on a continuum of Emerging, Promising Impact, Promising Quality, and Best. Of the 14 policies assessed by the CDC, 8 were categorized as "Best" in the Evidence Strength Assessment (See Table). Such evidence-based guidelines can inform the way CHR programs proceed in terms of strengthening and expanding the workforce to meet the health and social needs of American Indian communities.

Evidence-based CHW/CHR Workforce Policy Guidelines	Quality Score	Quality Score	Evidence Category
1. CHWs provide chronic disease care services (Chronic Care)	40	40	Best
2. Inclusion of CHWs in team-based care model (Team-based Care)	33	33	Best
3. Core competency CHW certification (Core Certification)	29	28	Best
4. CHWs supervised by health care professionals (Supervision)	28	26	Best
5. Standardized core CHW curriculum (Standard Care Curriculum)_	26	28	Best
6. Medicaid payment for CHW services (Medicaid)	25	22	Best
7. Specialty area CHW certification (Specialty Certification)	21	28	Best
8. Inclusion of CHWs in development of their certification requirements (Certification Development)	21	24	Best

Community Health Representative (CHR) Movement

Moving forward, CHR Programs expressed the need for consistent meetings among Tribal CHR Programs to continue the work of exploring common CHR definitions and scope of practice – and identification of tools for the integration of CHRs within tribal public health and health care systems. To do so, Summit attendees decided to establish the 'CHR Movement' as a way to continue discussions and dialogue among CHR Programs. These meetings will serve as a space to discuss the progress towards certification, funding schemes and the shared barriers faced in expansion of the CHR workforce.

CHR Programs suggested the need for a website that could be used by tribal members and CHRs to enhance networking opportunities and monitoring their progress as it relates to the CHR workforce. CHR Programs felt that having a message board within the website would facilitate cohesiveness when developing core competencies, definitions, goals and the scope of practice of CHRs.

At the policy level, CHR Programs stated the need to educate current and future CHRs about the progress towards voluntary certification and how the Affordable Care Act (ACA) supports third party reimbursement for their services. Political support at the tribal level is key to moving the CHR workforce towards voluntary certification.

CHR Programs suggested the need to support tribal resolutions, a policy mechanism that affects the welfare and rights of tribal governments and communities. This support would recognize the importance of the CHR workforce

during informational sessions with the health committee in the house to move the certification initiative forward on behalf of all CHRs.

Next Steps

The CHR Movement now meets bi-monthly via webinar and telephone. As a result of these calls, and in follow up to recommendations that emerged for the CHR Policy Summit, University of Arizona, College of Public Health doctoral students with extensive lived and professional experience with CHR programs and tribal communities developed a CHR Advocacy Toolkit (Appendix D). Such a toolkit serves to raise awareness about the CHR workforce and policy opportunities as well as inform tribal stakeholders about CHR voluntary certification and how it further elevates the CHR profession. Through active participation and input by CHR Movement members – students finalized the CHR Advocacy Toolkit which is available on the Arizona Advisory Council on Indian Health Care website. As we move forward on statewide policy initiatives we encourage CHR Programs to modify the CHR Advocacy Toolkit to meet their CHR Program needs.

Contents of the **CHR Advocacy Toolkit** are appended to this report and include:

1. Tribal Resolution to Support the CHR Workforce
2. Legislative Brief
3. Letter to the Editor
4. Elevator Speech

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Appendix A: Planning Committee

The University of Arizona, Arizona Prevention Research Center and the Center for American Indian Resilience, in collaboration with the Advisory Council on Indian Health Care, the Inter-Tribal Council of Arizona, Navajo Nation Community Health Representative and Outreach Program, Arizona Community Health Outreach Worker Association (AzCHOW) and Arizona Department of Health Service – Liaison to American Indian Affairs conducted one face to face meeting and four teleconference calls to plan and organize a statewide meeting of CHR programs. This planning committee continues to meet to plan and facilitate the CHR Movement webinars and teleconferences.

Appendix B: CHR Policy Summit Agenda

Community Health Representative Policy Summit: Certification, Reimbursement and Sustainability for Healthy Communities

Tuesday, September 1, 2015

12:00 p.m. - 5:00 p.m.

Little America Hotel | 2515 E Butler Ave., Flagstaff, AZ 86004

Emcee: Mr. Michael Allison, Native American Liaison, Arizona Department of Health Services

AGENDA		Learning Objectives
11:00 a.m.	**Registration Opens**	
12:00 p.m.	**Welcome and Overview of Meeting Objectives** - **Kim Russell,** Executive Director, Arizona Advisory Council on Indian Health Care	This session introduces ourselves and lays out the objectives for the meeting which include: 1. Explore national, state and tribal issues regarding CHWs/CHR reimbursement through Medicaid. 2. Increase awareness of Arizona and New Mexico CHW certification processes and legislation. 3. Explore benefits and costs to CHW/CHR certification in Arizona.
12:15 p.m.	**Introductions and Blessing of Food**	Lunch is served
1:00 p.m.	**National CHW/CHR Sustainability Initiatives** - **Samantha Sabo**, Arizona Prevention Research Center, Zuckerman College of Public Health, University of Arizona	This session focuses on the state of CHW certification, reimbursement and sustainability in the context of U.S. health reform.
1:20 p.m.	**CHW Sustainability, Reimbursement, Certification in New Mexico** - **Mae-Gilene Begay**, Director, Navajo Community Health Representative Program and Chair, Community Health Worker Section, American Public Health Association (APHA) - **Diana Abeyta**, Tribal and Northern Coordinator, Office of Community health Workers, New Mexico Department of Health	This session focuses on the certification process including the board of certification, what they have accomplished so far, and why it is important.
2:00 p.m.	**Arizona CHW Workforce Coalition Efforts Toward Statewide CHW Certification** - **Floribella Redondo**, President Arizona Community Health Worker Outreach Network (AzCHOW) - **Yanitza Soto**, Community Health Worker Manager, Arizona Department of Health - **Andy Logue**, MPH/JD Intern, Zuckerman College of Public Health, University of Arizona	This session describes the efforts of the Arizona Community Health Worker Outreach Network (AzCHOW) and the Arizona CHW Workforce Coalition to bring about consensus on CHW certification legislation and the required sunrise application process for Arizona health professionals.
2:30 p.m.	**Coffee and Snack Break**	
2:45 p.m.	**Summary and Implications for Tribal CHR Programs and Beyond** - **Alida Montiel**, Director of Health Systems, Inter Tribal of Council of Arizona, Inc.	This session focuses on the role of CHR's in the Indian health system and mechanisms by which preventative services deemed mandatory or optional services may be incorporated in the Section 1115 Demonstration in order to institute

		100% Federal pass-through reimbursement to Tribes.
3:15 p.m.	**CHR Workforce Sustainability Roundtables** - **Mae-Gilene Begay, Samantha Sabo, Kim Russell** - Topic 1: Certification - Topic 2: Financing and Reimbursement	This session is small group discussions on the benefits and costs to CHR certification and reimbursement.
4:15 p.m.	**Roundtable Report Outs**	Each session leader will summarize main points made by participants.
4:30 p.m.	**Summary of Meeting and Next Steps** - **Kim Russell**, Executive Director, Arizona Advisory Council on Indian Health Care	Identifies next steps and action items
4:50 p.m.	**Thank you, Evaluation and Raffle!** **- Kim Russell, Samantha Sabo, Mae-Gilene Begay and Tara Chico**, UA Center for American Indian Resilience	Win BIG Prizes for completing your CHR Workforce Assessment! *(Place your evaluation in the box and raffle ticket anytime during the event)*

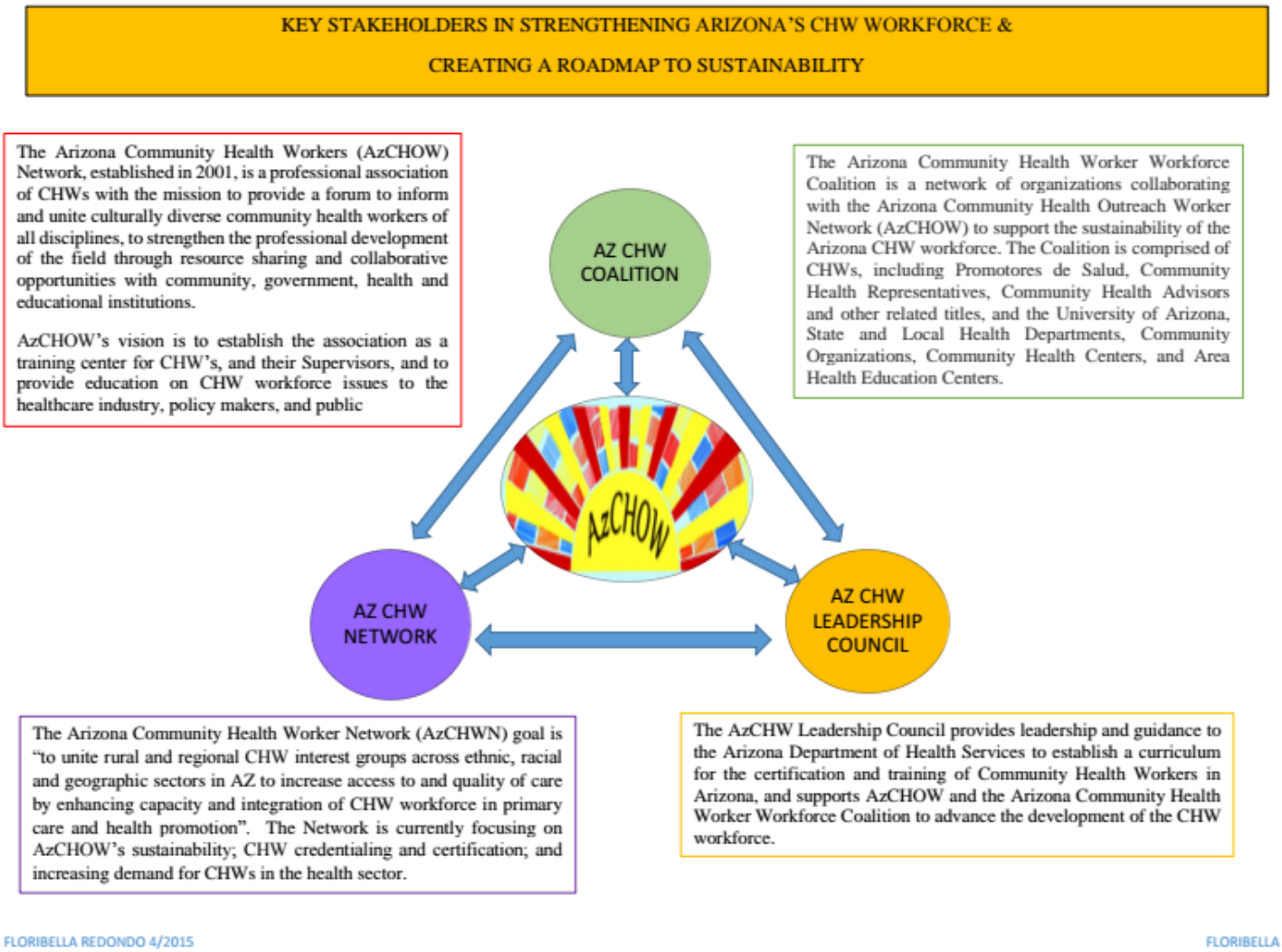
Event Collaborators: Arizona Advisory Council on Indian Health Care, University of Arizona, Zuckerman College of Public Health - Arizona Prevention Research Center and the Center for American Indian Resilience, Arizona Department of Health Services, Inter Tribal Council of Arizona, Inc., Navajo Nation CHR Program, the Arizona Community Health Worker Outreach Worker Association.

Event Sponsors: University of Arizona, Arizona Health Education Centers (AHEC) Small Grants Program funded to the University of Arizona, Zuckerman College of Public Health - Arizona Prevention Research Center and the Center for American Indian Resilience.

Information Tables – be sure to check them out!

- **University of Arizona, Zuckerman College of Public Health** – information on undergraduate, graduate, online and doctoral programs in public health (https://publichealth.arizona.edu/prospective-students
- **University of Arizona, Center for American Indian Resilience** http://cair.arizona.edu/
- **Arizona Community Health Worker Outreach Network** https://www.facebook.com/arizonachw
- **Southeast Area Health Education Program** – Native American Health Workforce efforts http://www.seahec.org/
- **Family Spirit Program** http://www.jhsph.edu/research/affiliated-programs/family-spirit/
- **Summer Health Research enhancement Program (SREP)** (open to all tribes) http://www.dinecollege.edu/institutes/SREP/srep.php

Appendix C: Community Health Worker Stakeholder Groups



Appendix D: Community Health Representative Advocacy Toolkit

RESOLUTION NO.___201_
OF THE GOVERNING BODY OF THE
[Tribe] OF THE [Tribe] RESERVATION
[Tribe] TRIBAL COUNCIL

THE IMPORTANCE OF COMMUITY HEALTH REPRESENTATIVES IN TRIBAL COMMUNITIES AND THE NEED FOR ARIZONA TO RECOGNIZE THE COMMUNITY HEALTH REPRESENTATIVES IN THE WORKFORCE

WHEREAS, the [Tribe] Tribal Council is responsible for the health, safety, education and welfare of all community members; and

WHEREAS, the [Tribe] has the health of the [Tribe] people as a priority as demonstrated by their support of health promotion and disease prevention initiatives; and

WHEREAS, Community Health Representatives (CHRs) are trusted, community based tribal paraprofessionals who serve as intermediaries between health service providers and community members; and

WHEREAS, Community Health Representatives services have been shown to improve patient health outcomes, knowledge, lifestyle and self-management behaviors among patients; and

WHEREAS, Community Health Representatives have been found effective for improving specific knowledge about cancer, cervical and breast cancer screening; and

WHEREAS, the [Tribe] recognizes the importance of Community Health Representatives and their vital role in improving the control of hypertension, diabetes and other chronic diseases that adversely affect the [Tribe]; and

WHEREAS, the [Tribe's Health Department, Division of Health, or Department of Health, Education and Wellness] manages programs that engage Community Health Representatives to address health needs and education of community members; and

NOW THEREFORE BE IT RESOLVED, the [Tribe] hereby approves to support recognizing Community Health Representatives in the workforce, and to further request the elected tribal council members to support fully the intent and purpose for the Health of [Tribal] members.

CERTIFICATION

The [Tribal Council] authorizes the [Chairwoman, Chairman, President] or [Vice-Chairman, Vice-Chairwoman or Vice-President] to negotiate and execute any and all agreements and contracts pertaining to the Community Health Representative Movement.

I, the undersigned as [Chairperson] of the [name] Tribal Council hereby certify that the [name] Tribal Council is composed of [number of council members] of whom ( ), constituting a quorum, were present at a regular council meeting held on the ___ day of _____, 201_; and that that the foregoing resolution was duly adopted by a vote of ( ) in favor ( ) opposed ( ) not voting, ( ) excused, pursuant to authority of the Constitution of the [name] Tribe, approved [date constitution was ratified].

Name and title of Chair/President

[Name] Tribal Council

ATTEST:

[Name], Secretary

[Name of Tribe] Tribal Council

COMMUNITHY HEALTH REPRESENTATIVES

Federal Medicaid Reimbursement of Rural Arizona's Frontline Health Workers

The Issue

Arizona's American Indian (AI) population currently experiences significant health care disparities high mortality rates from heart disease, diabetes, injury related deaths, cancer and youth suicide, among many other areas (Arizona Health Disparities Center, 2014). An October 2015, "State of Obesity" identified Arizona's tribal obesity as the most severe in the nation (Blanton, 2015). For the maternal and child health population, the state's AI population has high rates of teen pregnancy, unintended pregnancy, preterm births, and infant mortality (ADHS, 2012).

The Role of CHRs

A CHR is a Community Health Worker (CHW), who is a trusted member of the community (Walkup, 2009). Indian Health Services (IHS) initially established the CHR program in 1968 to provide patients with health education, screening, healthcare counseling, advocacy and transportation (IHS, 2015). CHRs provide a variety of services for every stage of life, such as transportation to dialysis, sponsor community health promotion events, provide prenatal, parenting and breastfeeding education, and teach a school health class, among many other services (IHS, 2015). Due to extremely limited IHS funding, CHRs are drastically understaffed and overworked in tribal communities. A 2015 report from the first Arizona gathering of CHRs is a grassroots call to action for policymakers to recognize the impact that CHRs are making and expanding the CHR workforce by authorizing Arizona Health Care Cost Containment System (AHCCCS) and other third party sources to reimbursement CHR services (Sabo & Chico, 2015).

Executive Summary

Community Health Representatives (CHRs) are trusted, community-based tribal professionals who serve as intermediaries between health service providers and community members. CHRs are vital to patient-centered care because they provide culturally enhanced services to rural, high-risk tribal populations. Services provided to Arizona Health Care Cost Containment System (AHCCCS)- eligible American Indian patients in IHS or tribal facilities can be reimbursed at 100% Federal Medicaid Assistance Percentage (FMAP) at no cost to the State. The policy recommendation is for Arizona to recognize CHRs as part of the patient-centered medical home. State AHCCCS recognition of CHRs enables tribes to leverage federal Medicaid funding to expand the CHR workforce, improve the quality of services, and serve Arizona's highest risk communities.

Policy Recommendations

- Voting in favor of state recognition of Community Health Representatives (CHRs) as members of a patient-centered health care team means *federal* reimbursement of CHR services to tribal health facilities (states do not lose money) and opens the pathway for other third party reimbursement options for tribal health facilities. It will also expand Arizona's rural health workforce, which will enable tribes to address their health disparities in a culturally appropriate way.
- Establishing an Office of Community Health Worker will elevate the professional status of Arizona's Community Health Worker workforce and provide a means for continued resource and professional development.

Policy Implications

By expanding payment options and shifting to a value-based reimbursement structure, the Affordable Care Act (ACA) supports the merging of CHRs into the mainstream continuum of care. The AHCCCS 1115 Demonstration Waiver currently proposes the establishment of an Indian Health Medical Home (IHMH) Program. The IHMH coordinated care model focuses on patient- and family-centered care through the use of health care teams (Community Health Representative Policy Summary Report, 2015). Based on existing Community Health Worker (CHW) research, CHRs could prove to be a valuable member of this team (Norris et al., 2006).

In terms of policy implications, various analyses have yielded positive CHW results (CDC, 2015):

- Improved hypertension control in high-risk populations;
- $157 and $190 per patient reduction costs for every 1% drop in systolic pressure and 1% drop in diastolic pressure, respectively;
- Improved appointment fidelity, greater prescribed care compliance, risk reduction, blood pressure control, and related mortality;
- Improved cancer screening rates; and
- $1,150 savings per participant and improved life expectancy in a colorectal cancer screening study.

CHR functions:

- Health education
- Screening
- Health care counseling
- Advocacy
- Transportation
- Translation services
- Elder care
- School and community-based outreach
- Referrals to community

Policy Options

While Arizona's American Indian population currently experiences significant health care disparities, there is hope for improvement if AHCCCS expands their definition of reimbursable services to include CHRs. Policymakers and legislators can actively move to improve the health of Arizona's American Indian population by taking the following steps:

- Mandate that AHCCCS officially recognize Community Health Workers and Community Health Representatives as valuable members of a patient-centered health care team and "agents of change" in community level health;
- Support expansion of the CHR workforce by authorizing AHCCCS and state health insurance providers to include CHR services in the list of reimbursable services;
- Follow New Mexico's lead by establishing an Office of Community Health Worker that will function to elevate the professional status of Arizona's Community Health Worker workforce and provide a centralized means for continued resource and professional development.

The Bottom Line

Since all reimbursements to tribal health facilities come from the federal government, Arizona policymakers have nothing to lose by voting in favor of formal CHR recognition. It is a win-win scenario for Arizona stakeholders. Policymakers increase federal funding streams into Arizona, assist the state's most high-risk populations, and provide tribal health facilities with a means for increasing their workforce capacity. Ultimately, policymakers have the potential to save Arizona millions in state AHCCCS funds by voting in favor of CHR recognition.

LETTER TO THE EDITOR

TEMPLATE

Dear Editor:

Community Health Representatives (CHRs) play a vital role in addressing the gap of health care needs in Arizona's tribal communities. The lack of health care providers in rural communities continues to be a barrier for tribal nations and it is imperative that we recognize the role of CHRs in patient-centered care. Therefore, we ask readers to contact their Arizona legislator (www.azleg.gov) and urge them to support CHRs by voting in favor of (insert Bill name/number).

A CHR is a trained public health professional that advocates for their patient's health needs. Often times, we wear many hats within our community, we are: health educators, advocates, counselors, event coordinators, transporters (to medical appointments), and interpreters. We share the same language and culture as the communities we serve and have trusting relationships with our patients. We also help facilitate coordination of services for the betterment of our patients' lives.

Furthermore, our services have been shown to improve the health outcome of our patients, while improving the gap in health care services within tribal communities. For these reasons, CHRs should be recognized for our vital role in patient-centered care. We are the agents of change in shifting the focus from treatment to preventative services and improving the access to quality health care in our tribal communities.

Again, I ask your readers to support CHRs by contacting their representatives (www.azleg.gov) and urging them to vote to recognize CHRs (insert bill name/number).

Sincerely,

(Name)

Community Health Representative

(Tribe)

CHR MOVEMENT

TEMPLATE

Elevator Speech to Legislator(s)

As a Community Health Representative, I wear many hats within my tribal community: health educator, advocate, counselor, event coordinator, transporter, and interpreter. As CHRs, we are trained public health professionals who serve as intermediaries between healthcare providers and our patients. Because we are from the community and know the culture and language, our patients trust us. CHRs should be recognized for our vital role in patient-centered care. Our services have been shown to improve the health outcome of our patients. We are asking for your support by voting to officially recognize CHRs in the health workforce and paving the way for federal reimbursement of our essential services.